GME Enhancement Initiative

Expanding and Redirecting VA Medical Resident Positions to Meet the Needs of Veterans and the Nation

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Office of Academic Affiliations

Veterans Health Administration

VA Trainee Workforce

- **Over 100,000 trainees annually**
  - **Medical Education (~50%)**
    - **Affiliations with 107/125 US allopathic and 15/25 osteopathic medical schools**
  - **Associated Health Education (~50%)**
- **Annual budget**
  - **$0.5 Billion (direct costs)**
  - **$0.5 Billion (indirect costs)**
  - **~80% devoted to GME**
- **VA is the second-largest supporter of GME in the U.S. (after CMS)**

VA GME Workforce (AY 2006-07)

- ~34,000 medical residents
  - 30% of U.S. residents
  - Over 2,000 ACGME-accredited programs in 79 different specialties and subspecialties
- ~9,000 individual resident salary lines
  - 8.6% of U.S. total
- 99% of programs are sponsored in the name of academic affiliates

Strategic Plan for GME

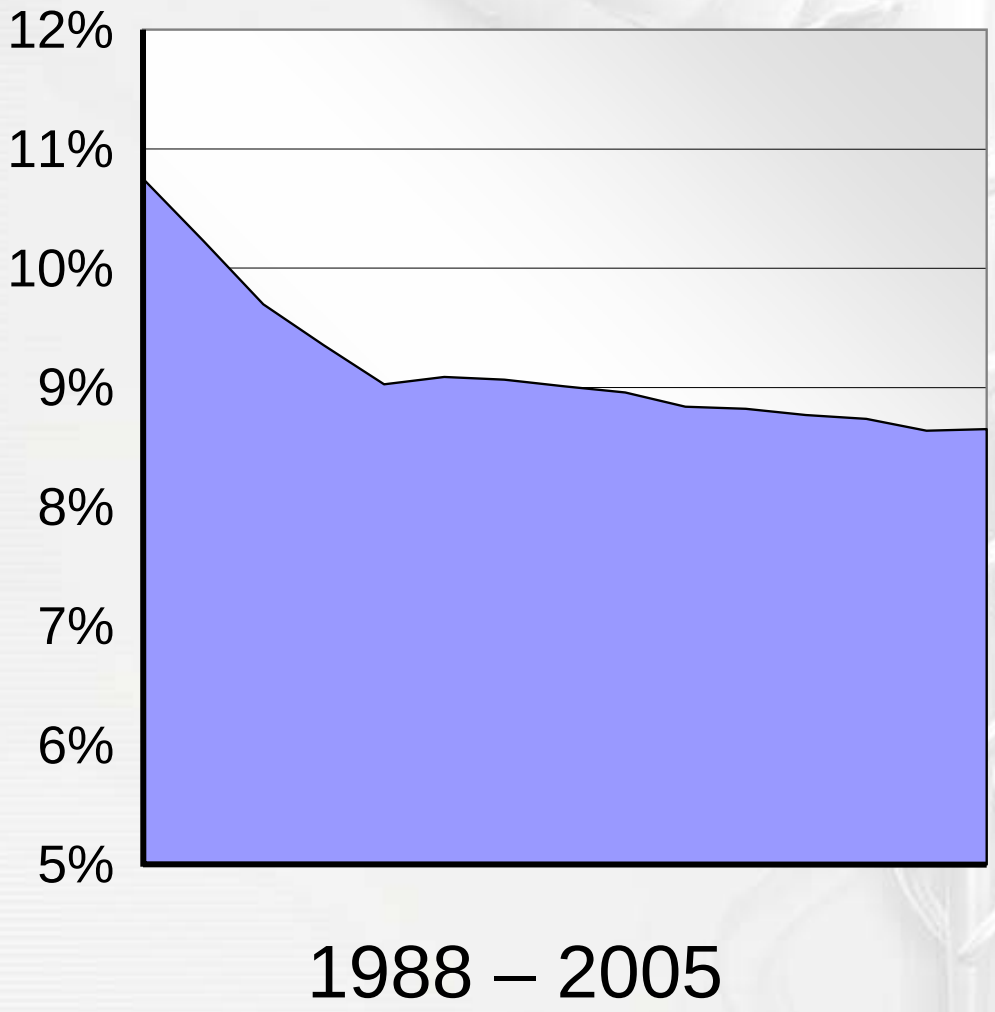
- **Short-term**
  - **GME expansion to meet accumulated needs**
- **Intermediate-term**
  - **Educational innovation projects to define future training opportunities**
  - **Educational infrastructure development**
- **Longer-term**
  - **System redesign to enhance learning and patient outcomes**

GME Advisory Committee (1)

- External Advisory Committee chartered by VA Secretary in 2004
- Major Findings:
  - Loss of proportionate share of GME positions
  - Little flexibility to meet VA's clinical needs for residents in emerging disciplines or for new facilities or treatment sites
  - Selective distribution of NEW positions (rather than redistribution of existing positions) was warranted

Loss of Proportionate Share

VA GME Positions
(% U.S. Total)



GME Advisory Committee (2)

- **Major recommendation: Restore VA-funded medical resident positions to 10-11% of U.S. total**
- **Approved by VA Secretary in fall 2005**
  - **First expansion of VA GME in over 15 years**
- **GME Enhancement Initiative launched in spring 2006 for AY 2007-08**
  - **2,000 new positions over 5 years**
  - **Estimated incremental cost: $250 million (direct and indirect costs)**

Present and Proposed VA Allocations Compared to U.S. Totals

Phase	Academic Year	US Positions[1]	VA Positions	VA/US (%)	New VA Positions
-	2005-06	104,681	8,851	8.5	0
-	2006-07	105,728	9,047	8.6	0
1	2007-08	106,785	9,389	8.8	342
2	2008-09	107,853	9,764	9.0	375
3	2009-10	108,931	10,189	9.4	425
4	2010-11	110,021	10,639	9.7	450
5	2011-12	111,121	11,145	10.0	506
TOTAL (5 YEARS)					2098

[1]US positions estimated to increase at 1% per year (actual increase over past 5 years = 1.3%)

GME Enhancement Initiative
Goals & Objectives

- Expand resident positions in specialties of greatest need to veterans
- Address uneven geographic distribution of residents and improve access to care
- Foster innovative models of resident education
- Assume VA's proportionate share in addressing the physician workforce shortage
- Enhance VA's leadership role in GME

GME Enhancement Initiative
Emphasis

- **Phase 1: AY 2007-08**
  - **RFPs issued in Spring 2006**
    - **Critical Needs (CN) & Emerging Specialties (ES)**
    - **New Affiliations (NA) & New Sites of Care (NS)**
- **Phase 2: AY 2008-09**
  - **RFPs issued in Spring 2007**
    - **CN & ES**
    - **NA & NS**
    - **Educational Innovation**
- **Phases 3-5: 2009-12**

GME Enhancement Initiative
Allocation Methodology

- **Distribution of positions based upon two independent factors**
  - **Quality of training experience**
    - **Peer review panel of VHA GME experts rank facilities' applications for residents**
  - **Capacity to train**
    - **Newly developed measure of health care services ("Resident Education Index")**

GME Enhancement Initiative
Educational Quality Criteria

- Facility and VISN commitment to education
- Strong local educational leadership
- Appropriate educational objectives and clinical activities
- Robust academic affiliations
- Track record for excellence in GME
- Administrative infrastructure
- Programmatic evaluation strategies

GME Enhancement Initiative
Resident Education Index

- **Background:** residents contribute to workload, but at rates different than attending physicians
- **Objective:** to measure the capacity of individual specialty groups within given facilities to train residents
- **Describes** the amount of patient care a facility provides relative to an "average" facility with the same resources
- **Distinguished** from traditional workload ratios, which rely on ***available clinical workload*** rather than ***actual care provided***

Resident Education Index Calculation

$$\text{Res Ed Index} = \frac{[\textit{actual}\ \text{health services}] - [\textit{expected}\ \text{health services}]}{[\textit{expected}\ \text{health services}]}$$

- Where, "*actual* health services" = amount of health care services that a given facility actually provided
- And, "e*xpected* health services" = amount of health care services produced by an average facility if it had the same number and mix of residents, other professional staff, support services and equipment as the index facility
- **INTERPRETATION:** If > 0, the facility is above average in terms of producing health care services with the available resources

Resident Education Index
Key Characteristics

- Provides an "adjusted relative workload" for each specialty group (medicine, surgery, psychiatry)
- Allows comparisons between hospitals by specialty groups
- Re-computes patient care opportunities as residents are added to each specialty group
- Provides a measure of the "return on investment" in residency training

Resident Education Index
Summary

- **Allocating new physician residency positions based upon the Resident Education Index has the potential to:**
  - **Enhance veterans' access to care**
  - **Expand residents' learning opportunities**
  - **Increase the efficiency of health care resource utilization**

GME Enhancement: Phase 1
Allocation Formula

- **Allocation of new positions took into account:**
  - **Quality score (peer review panel)**
  - **Res Ed Index by facility and specialty group (Medicine, Surgery, Psychiatry)**
  - **Facility's current number of resident positions by specialty**
  - **Distribution of positions requested by specialty (facility priorities)**
  - **Program expansion caps**

GME Enhancement: Phase 1
Overall Results

- **72 applications from 69 facilities**
- **All 21 VISNs represented**

RFP	Positions		
	Requested (n)	Approved (n)	Approved (%)
CN & ES	531	300	56
NA & NS	129	42	32
TOTAL	660	342	52

- **Max number positions approved/facility: 15**
- **All approved facilities received at least 1**

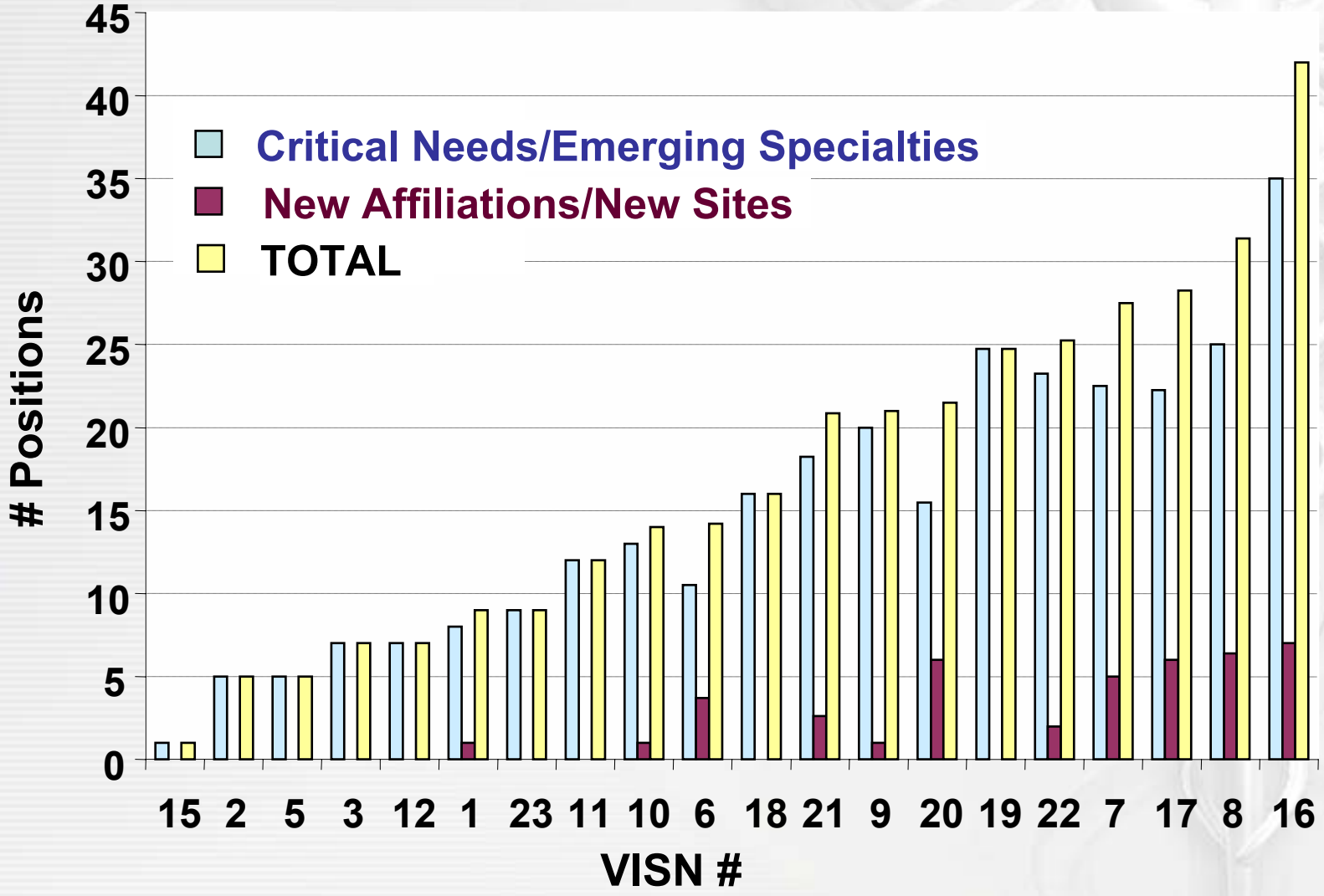
Positions Approved by RFP Subcategory

RFP	Positions Requested	Positions Approved	
		(n)	(%)
CN	409		
ES	122		
CN & ES	531	300	56
NA	85		
NS	45		
NA & NS	129	42	32
TOTAL	660	342	52

Positions Approved by Specialty

Specialty Group	2007-08			2006-07 Distribution (%)
	Programs (n)	Positions (n)	Positions (%)	
Generalist	2	36	10	39
Surgery & related	14	49	14	22
Specialty-other	29	185	54	21
Mental Health	4	48	14	10
Rehabilitation	2	12	3	2
Ancillary-Diagnostic	5	13	4	6
TOTAL	56	342	100	100

Positions Approved by VISN



Positions Approved by State

Resident Positions by State

45

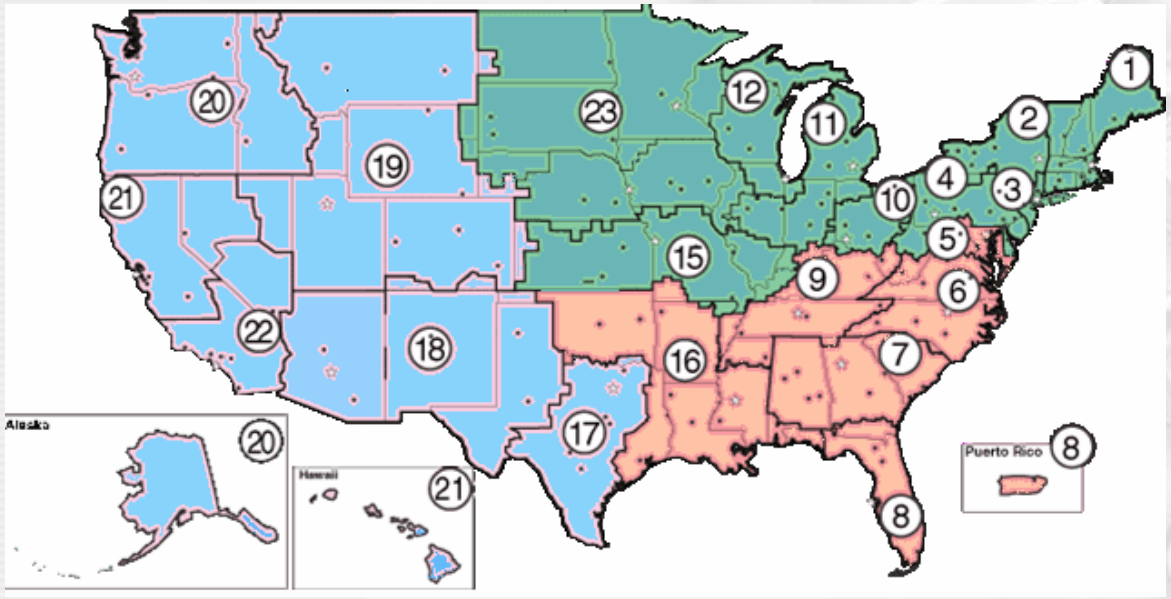
23

0

Top 10 States

TX	42
CA	42
FL	31
GA	16
OR	15
OH	14
UT	14
AL	12
NY	12
CO	11

Positions Approved by Region



REGIONS	CN & ES	NA & NS	TOTAL	%
NE, MA, MW	62	2	64	19
SE	118	23	141	41
NW, W, SW	120	17	137	40
TOTAL	300	42	342	100

Allocation Methodology: Phase 1

- **Allocation methodology takes into account:**
  - **Educational quality**
  - **Capacity to train**
- **Initial results suggest the method is:**
  - **Rational and defensible from a policy perspective**
  - **Demographically sensitive**
  - **A model for use in future allocations**
  - **Applicable to other healthcare systems**

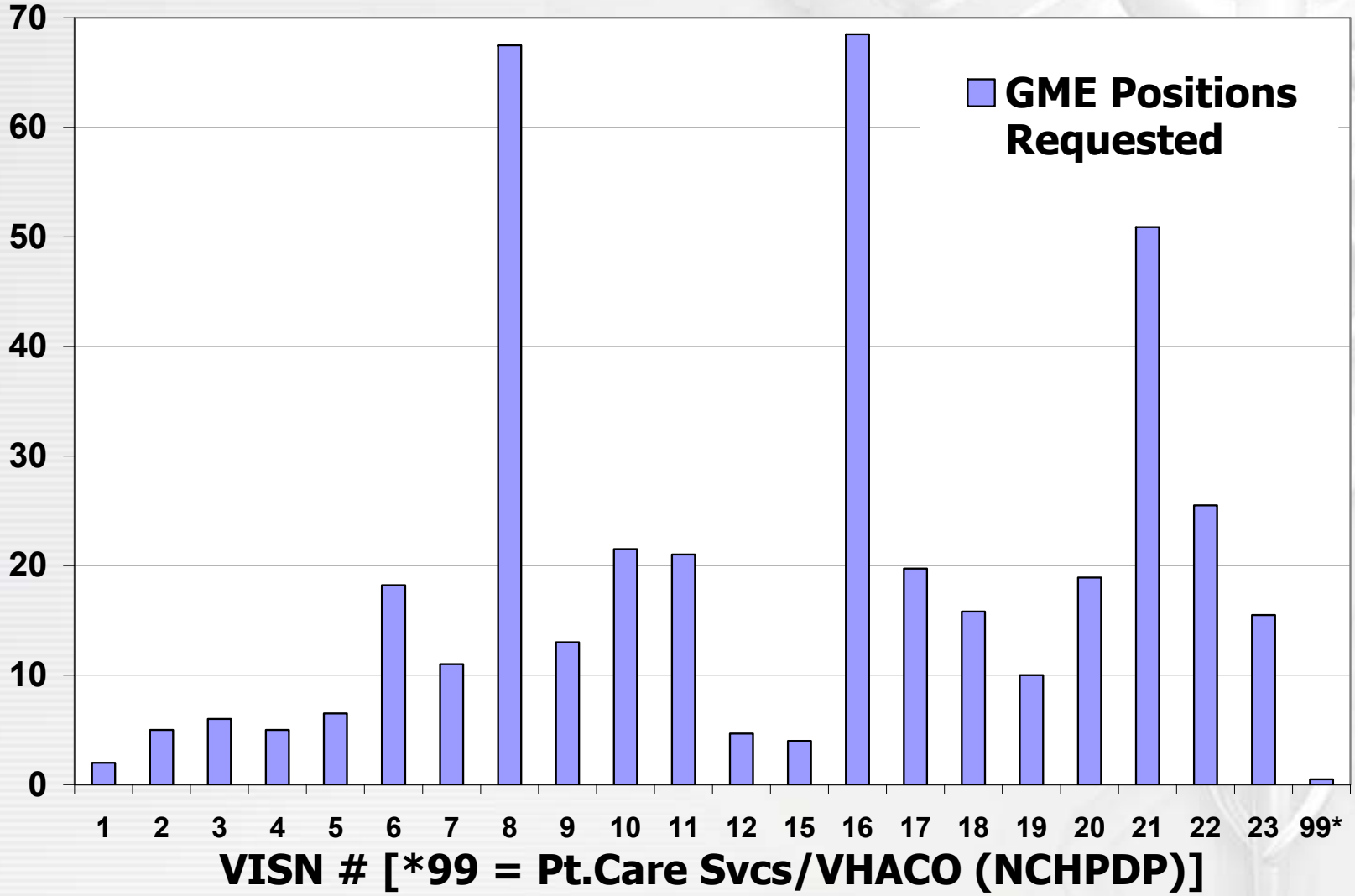
Applications: Phase 2

Program Type	# Sites	# Programs	# Positions Requested
Critical Needs/Emerging Specialties	47	241	321.31
New Affiliations/New Sites	12	25	56.4
Educational Innovation	14	16	33
TOTALS:*	60	282	410.71
TOTAL Site Requests:	73		
ACGME	58	272	391.21
AOA	3	10	19.50

** Note: 11 facilities applying for CN/ES also applied for Educational Innovations*

2 sites also applied for both CN/ES and NA/NS

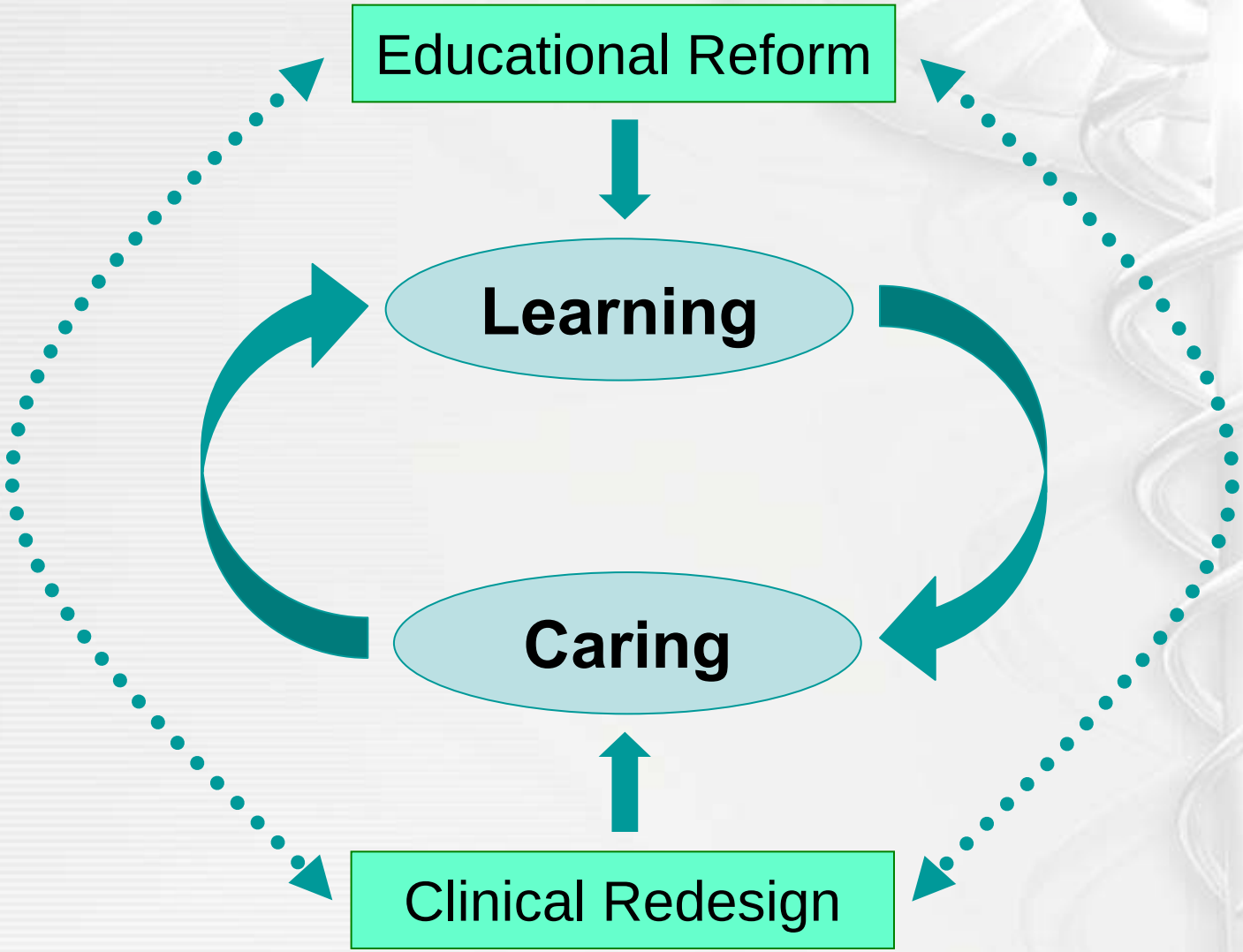
GME Enhancement Phase 2:
Applications by VISN



Educational Reform: Prerequisites

- **Evidence-based practice**
  - **Scientific literacy**
    - **Traditional sciences**
    - **"New" behavioral & population sciences**
- **Patient-centered care**
  - **Humanism**
  - **Medical professionalism**
  - **Continuity**
    - **Patient care**
    - **Learning environment**

Educational Innovation: Vision



Program Eligibility

- Restricted to ACGME-accredited programs
  - (primary programs, exclusive of subspecialties)
- Modeled on the ACGME RRC-IM Educational Innovation Project (EIP)
- At least two accreditation cycles with…
  - Minimum of 8 years in good standing
  - Current minimum 4-year accreditation cycle
- ABMS board pass rate ≥ 80% for…
  - Rolling 3-yr average
- Annual progress report to VA and ACGME that includes…
  - Educational and clinical outcome measures

Institutional Eligibility

- **Innovation**
  - **Transform educational processes**
  - **Redesign clinical care models**
- **Commitment**
  - **Protect teaching time**
  - **Support professional development**
- **Assessment**
  - **Measure educational and care outcomes**
  - **Participate in cross-site program evaluation**

Challenges

- **Structural Challenges**
  - Educational infrastructure
  - Clinical infrastructure
- **Regulatory Challenges**
  - Accreditation policies & procedures
  - Medicare policies & procedures
- **Other Challenges**
  - Cultural (resistance to innovation)
  - Lack of educational outcomes data
  - Financial (direct and indirect GME support)

Educational Infrastructure

- **Educational leadership**
  - **ACOS-Education (DEO)**
  - **Professional development**
  - **Administrative support**
- **Clinical faculty support**
  - **Protected time**
  - **Continuing education**
  - **Sabbatical authority**
- **Operational support**
  - **Reformulation of VA's "indirect" support for education (currently $51K/medical resident FTEE)**

ACOS-Education

- **Qualifications**
  - **Educational expertise**
  - **Leadership & management skills**
  - **Academic credibility**
- **Role and responsibilities**
  - **Appointment authority**
  - **Span of control**

Professional Development

- **Educational conferences**
  - **Annual DEO meeting**
  - **AAMC membership**
    - **Joint meetings with AAMC's GRA**
- **Advanced training**
  - **Mental Health Clinical Scholars program**
  - **VA-RWJ Faculty Scholars program**
  - **Educational Research Centers of Excellence**

Clinical Infrastructure

- **Professional services support**
  - **Nursing**
  - **Associated Health**
- **Technical support**
  - **Radiology**
  - **Laboratory**
- **Administrative support**
  - **Appointments & scheduling**

Regulatory Challenges

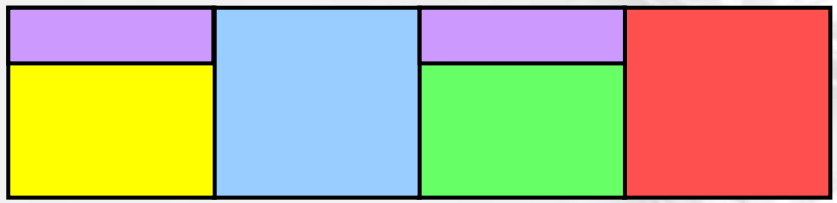
- **ACGME/RRC program requirements**
  - **Heavily regulated, tightly scheduled educational programs**
- **Specialty Board eligibility requirements**
  - **Requirements based upon training "time" rather than competency-based advancement**

Cultural Challenges

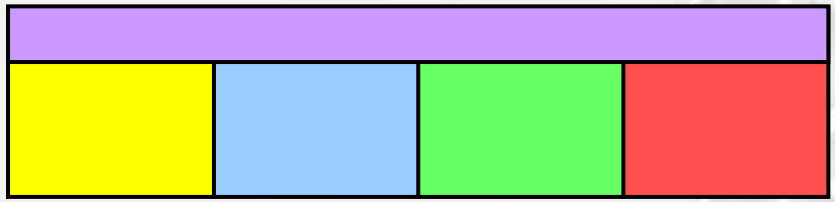
- **Traditional clinical rotations limit opportunities for residents to become involved in…**
  - **Patient-centered, collaborative care**
  - **Longitudinal care models**
  - **Patient safety**
  - **Quality improvement**
  - **System re-design**

Ambulatory Care: The Problem

BLOCK



LONGITUDINAL

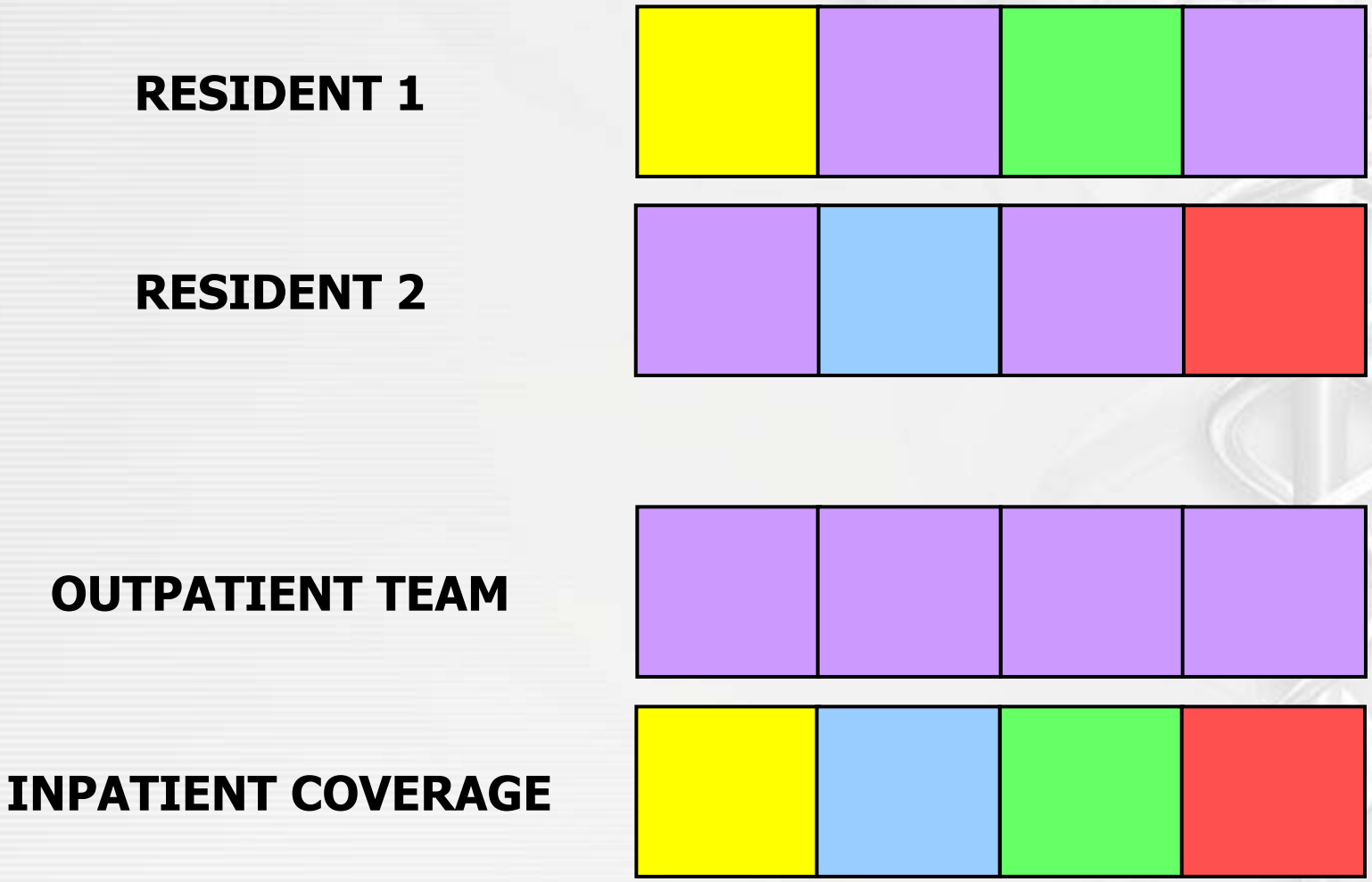


Implementation of ACA in VA

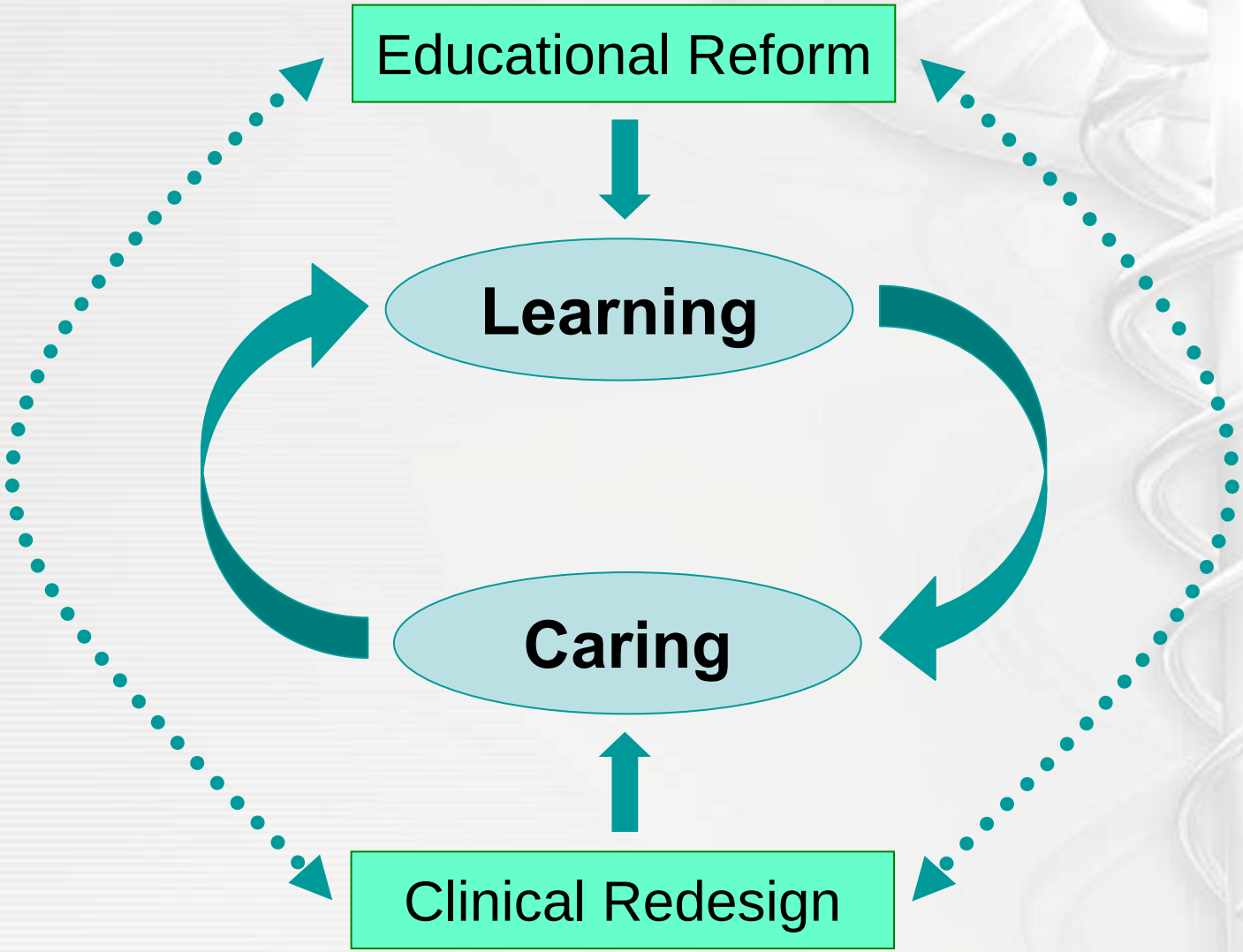
Selected ACA Components	Staff Clinics (n = 92)	Teaching Clinics (n = 70)
Open Scheduling and Recalls	49%	17%
Leave Coverage	55%	29%
Planning for Contingencies	51%	29%
Prediction of Patient Needs	50%	29%
Optimizing Patient Involvement	60%	31%
Optimizing Team Care	60%	33%
Mean ± SD Implementation (n=19)	59±12%	32±9%

Chang BK et al. Resident Physicians in VA Outpatient Clinics: Continuity and Advanced Access Implementation. *Federal Practitioner* 24(5): 35-54, May 2007.

Ambulatory Care: A Potential Solution



System Redesign



Summary

- **VA is expanding residency training positions in ways that will:**
  - **Address specialty and geographic needs**
  - **Expand veterans' access to care**
  - **Enhance residents' clinical training experiences**
  - **Contribute to reform and innovation in medical education, while improving care delivery**